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ABSTRACT

This study was conducted to compare the effectiveness of family functioning in families who have become homeless and poor families who have never been homeless. Relying on the McMaster Model of Family Functioning, it focused on family functioning in terms of transactional patterns or the family's mode of interaction as a unit. Subjects consisted of 18 homeless and 24 housed single mothers. The homeless mothers had a mean age of 25.2 years and an average of 2.8 children. The mean age of housed mothers was 26 years, with an average of 2.2 children. Family functioning was assessed using the McMaster Family Assessment Device, with homeless mothers basing their responses on retrospective judgments. Analyses revealed significant differences between homeless and housed families on several integral areas of family functioning. Results suggest that prior to becoming homeless, homeless families were not likely to be as effective in solving problems, communicating, responding affectively to one another, being involved with other family members, or in general family functioning, as poor housed families. The data do not allow these differences to be attributed to inherent psychological differences. The difficult social and economic circumstances prior to becoming homeless may well impinge on family functioning.
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Psychosocial Functioning in Homeless and Poor Housed Families

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Abstract

The present study compares the effectiveness of family functioning in families who have become homeless and poor families who have never been homeless. Relying on the McMaster Model of Family Functioning, this study focuses on family functioning in terms of transactional patterns, that is, the family's mode of interaction as a unit (Epstein, Bishop, & Baldwin, 1982).

Subjects consisted of 18 homeless and 24 housed single mothers. The homeless mothers had a mean age of 25.2 years and an average of 2.8 children. The mean age of housed mothers was 26 years, with an average of 2.2 children. Family functioning was assessed using the McMaster Family Assessment Device, with homeless mothers' basing their responses on retrospective judgements.

Analyses revealed significant differences between homeless and housed families on several integral areas of family functioning. Results suggest that prior to becoming homeless, homeless families were not likely to be as effective in solving problems, communicating, responding affectively to one another, being involved with other family members, as well as general family functioning, as poor housed families. The data does not allow these differences to be attributed to inherent psychological differences. The difficult social and economic circumstances prior to becoming homeless may well impinge on family functioning.

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Psychosocial Functioning in Homeless and Poor Housed Families

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I would like to begin the report of my research with a preface. In the U.S. today, poor families are confronted by numerous problems: lack of housing, under and unemployment, social disaffiliation, family and street violence, cutbacks in social welfare spending, the decay of the traditional nuclear family, and an increase in the number of families living below the poverty level. It is against the backdrop of some or many of these problems that poor families struggle, not only to maintain themselves physically, but also to survive psychologically, as a family. In spite of their efforts, some families eventually fall through the so-called safety nets and become homeless. The obvious question is "What are the differences,

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if any, between those poor families who become homeless and those who do not?" Numerous answers to this question have been proposed. Some have suggested factors inherent in the families or family members, such as certain personality characteristics. Still others attribute the difference to environmental or socio-political characteristics, for example, an attitude of callous disregard for the poor.

If one attributes the differences between homeless and housed individuals to personality characteristics, usually deficits, of the family or its members, the consequence is usually to blame the victim. This explanation invokes motivation - a cherished category for us psychologists. On the other hand, if one attributes the differences entirely to environmental or socio-political factors, it can result in the naming of global and diffuse causes. In both cases, these so-called causes lead to rationalizations for inaction in which no effective preventive or interventive services are delivered. If the victim is assumed to be the reason for homelessness, then it is argued, intervention is useless unless the victim wants to change the undesirable characteristics about her or himself. If societal conditions are perceived as the cause, then it is argued that there is no way that anything can be done. The problem is too all-encompassing and overwhelming.

A more conservative approach would argue that homelessness is not the result of a single cause or class of causes, either personal or environmental, but rather is the end result of the interaction of numerous conditions - lack of housing, drug addiction, social policy, violence and abuse, etc. Furthermore, at this point in time, research

does not seem to be at the place in the study of homelessness where it can decipher what is cause and what is effect. At best it can specify related conditions or circumstances. If the presence or absence of a particular condition differentiates between homeless and housed families, we cannot assume that this condition or lack thereof causes homelessness.

However, in spite of the problems with the question, and its potential for misinterpretation, learning "what differentiates families who become homeless from those poor families who do not become homeless" is an important task. If we can specify co-existing conditions, not causes, then we can identify some of the needs of these families and provide constructive intervention. Such interventions may assist them to deal more effectively with the conditions that ultimately contribute to homelessness. The solution is not to avoid the question of what distinguishes homeless and housed families and individuals, but to make every effort to address it responsibly and in ways that ultimately will help to prevent homelessness.

Previous research has provided significant insight into the broad outlines of the psychosocial issues which homeless families encounter. It suggests that the stresses these families experience manifest themselves in a number of different ways: more limited social supports (Bassuk, Rubin & Lauriat, 1986; McChesney, 1986), relationships with men who are more likely to have poor work histories and more alcohol and substance abuse problems than the men with whom housed women establish relationships, (Bassuk & Rosenberg, 1988), family violence in the form of battering and sexual

abuse of the women, a greater incidence of drug, alcohol and serious psychiatric problems (Bassuk & Rosenberg, 1988), and more frequent moves and more frequent living alone (Bassuk & Rosenberg, 1988).

The stress in homeless families is clearly evident in the children who manifest significantly more depression, anxiety behavior problems developmental delays and school problems than a normative sample of children. (Bassuk & Gallagher, In press; Bassuk & Rosenberg, 1988). The presence of these problems (substance abuse, violence, lack of social support, childhood histories of abuse, depressed and anxious children) would suggest that family functioning is significantly disrupted in homeless families.

The present study was designed to compare the effectiveness of family functioning in families who have become homeless and those who are poor, housed and have never been homeless.

Family functioning is defined here as the way in which families interact as a family unit, that is, the transactional patterns of these families It assesses the "explicit and implicit rules of a family, plus the action by members, which govern and monitor each other's behavior." (Epstein & Bishop, 1973, p.176). This approach reflects the McMaster Model of Family Functioning (Epstein, Bishop & Baldwin, 1982) and stands in contrast to other approaches which assess different aspects of the family, for example, family environment - i.e., the emotional contexts in which families function (Moos & Moos, 1976) or the family's perception of its needs (Dunst, Trivette & Deal, 1987). The McMaster Model, which has evolved from studies of normal as well as clinical populations, does not cover all aspects of family functioning. Rather, it focuses on the dimensions of

functioning that are seen as having the most impact on the emotional and physical health or problems of family members (Epstein, Bishop & Baldwin, 1982).

Effective family functioning is defined according to the McMaster Model as the ability to successfully negotiate six domains in which families are required to function (Epstein, Bishop and Baldwin, 1982). Problem solving refers to a family's ability to resolve problems that are both "instrumental" (related to the provision of food, clothing, housing, transportation, etc), and "affective" (that is, related to issues of emotion or feeling). The dimension of communication addresses the exchange of information within a family with respect to both instrumental and affective areas. The dimension of roles defines the repetitive patterns of behavior by which family members fulfill family functions such as the provision of resources, nurturance and support, and the development of children. Affective responsiveness refers to the ability to respond to a given stimulus with the appropriate quality and quantity of feelings, that is, the ability to express the full spectrum of feelings from anger to love in a manner that is consistent with the stimulus. Affective involvement encompasses the extent to which the family shows interest in and values the particular activities and interests of each family member. Behavior control refers to the pattern a family adopts for handling behavior in three areas: situations that are physically dangerous, situations that involve meeting and expressing psychobiological needs and drives, and situations that require interpersonal socializing behavior both between family members and with people outside the family.

It was anticipated that the families who became homeless would exhibit more problems in family functioning than poor housed families, and that the findings of the study would suggest intervention strategies, not only with families who have become homeless, but also with families who are at risk for becoming homeless.

METHOD

Subjects. Eighteen homeless and twenty-four housed families, from two large Northeastern industrial cities were assessed. The homeless mothers had a mean age of 25.2 years, and an average of 2.8 children. All of the homeless mothers were single parents and were receiving benefits from Aid to Families with Dependent Children (AFDC). At the time of the interview they had been in the shelter for an average of approximately 13.7 weeks - a little over 3 months. The housed mothers, also single parents, had a mean age of 26 years and had an average of 2.2 children. All but one of the housed women were currently receiving AFDC benefits. Both homeless and housed families represented varied ethnic groups. There was with a somewhat greater percentage of minority families among the homeless group as is reported in other studies (e.g., First, Roth & Arewa, 1988). Thirty-six per cent of the homeless families were Caucasian, 32% were Afro-American and 32% Latino. Among the housed families, 45 % were Caucasian, 15% were Afro-American, 36% were Latino and 4% Asian.

Materials. Family functioning was assessed using the McMaster Family Assessment Device (FAD) (Epstein Baldwin, &Bishop, 1983).

The instrument itself has empirically sound psychometric properties (Epstein Baldwin, & Bishop, 1983). Additionally, it has been used widely, thus generating comparative data. The FAD protocol consists of 60 items describing some aspect of family functioning. To each item the subject responds with "Strongly agree", "Agree" "Disagree" "Strongly disagree". In addition to scores on each of the six subscales, this tool also provides a measure of General Family Functioning.

Because shelter living cannot be considered "normative", it was decided to assess the family functioning of homeless families as it occurred in a more typical or normal situation. Consequently, the homeless mothers were asked to answer the questions with respect to the last situation in which they were living on a relatively permanent basis prior to coming to the shelter. There was prior evidence in the literature that the instrument had successfully been used in this retrospective manner (Liepman et al., 1990).. For the group of homeless mothers in this study, 44% had come immediately to a shelter from their last permanent home. Eighteen per cent had come to the shelter from a hotel, and, 38% from a brief stay doubled up with relatives or friends.

Procedure: Homeless families were interviewed at either a family health clinic or at the shelter. All housed families were interviewed at a family health center. The interviews were usually conducted after a medical appointment. The subjects were introduced to the psychologist by a member of the health center or shelter staff, and asked if they wished to meet briefly with the psychologist to determine their interest in participating in a research project. The

purpose of the study and nature of the questions were then explained to the mother who was reassured that her choice would in no way affect her medical care in the case of the health center or the services she received in the case of the shelter. Neither the medical providers nor the shelter staff were informed of her decision regarding participation. Mothers then provided the examiner with informed written consent.

Because the majority of the children were under the age of five, the interviews were conducted only.with the mother, a method used in many previous studies with the FAD. Each item was read to the mother and she verbally indicated her response.

RESULTS

The FAD was scored according to the method of Epstein, Baldwin & Bishop (1983). Within this scoring system, the scores on each dimension can range from 1 through 4 - with 1 representing so-called "effective functioning" and a score of 4 represents "ineffective functioning."

Multivariate analysis of variance was used to assess whether homeless and housed families differed on the seven subscales of the FAD. A significant multivariate effect was found $F=5.77$ $(7,34)$ $p<.000$. Univariate F tests were calculated to identify which subscales were significant. These analyses revealed significant differences between homeless and housed groups on Problem Solving, Communication, Affective Responsiveness, Affective Involvement and General Functioning. (See Table 1). There were no significant differences between the groups on Roles and Behavior

Control. On each of the significant subscales, the scores of the families who became homeless indicated less effective functioning than that of the housed families.

DISCUSSION

The results suggest, that prior to becoming homeless, some families appear to have significant difficulty in specific areas of family functioning. They appear to be less effective in solving problems - both instrumental problems such as the provision of food and clothing, and affective problems relating to issues of emotion or feeling. Families who became homeless had more difficulty than housed families in recognizing that a problem existed, and in finding and implementing strategies for solving the problem. Similarly, these families had more difficulty in communicating about some family issues - both instrumental and affective. Their style of communication tended to be less clear and direct, that is, more masked (e.g., the content is vague or camouflaged) and indirect (e.g., giving the message to another person). In the domain of Affective Responsiveness, families who became homeless tended to have more difficulty than housed families with expression of feelings. If feelings were expressed, their range was narrower (e.g., negative feelings would be expressed and tender feelings would not or vice versa) or their level of intensity not always appropriate (e.g., overreacting or underreacting). Families who became homeless also reported difficulty in terms of appropriate levels of involvement with the lives of other family members (Affective Involvement). While the measure does not distinguish quantitatively between the

levels of involvement, a inspection of the responses indicated a preponderance of under-involvement - "no one seemed to care".

It is important to note that these two groups of families did not differ in terms of Roles. Perhaps because both groups were single parents with young children, there was little room for the groups to differ about who provided food, clothing and nurturance.

The homeless and housed families also did not differ on the dimension of Behavior Control - that is, how the children were managed. This would suggest either that this domain of behavior is not as affected by the stresses that the homeless families experienced or that it is a problem domain for both housed and homeless families.

It is important to note the limitations of this study. Because of the difficulty accessing shelters and the multiple demands on homeless mothers, the sample is small. Additionally, this study is retrospective. While the more ideal approach is predictive, the time and expense of studying large numbers of poor families and following these families over the years to determine which become homeless, precluded utilizing the ideal strategy in this research. Finally, the FAD instrument, while used in a number of studies with varied populations, is, as any family assessment instrument would be, far from perfect for use across a variety of ethnic groups and with single parent families.

Given the limitations, what sense can one make of these differences in family functioning between families who become homeless and housed families?

It may be that the families who became homeless experienced greater economic and social difficulties and that the pressure of these circumstances contributed to problems in family functioning. Or it may be that their style of functioning rendered the homeless families less able to cope with the economic and social pressures they experienced. In other words, in this study there is no way to determine if the relative difficulty in family functioning contributed to pushing these families into homelessness or was the result of the economic and social stresses that were leading to homelessness.

What we do know from this data is that families who eventually become homeless appear to experience significantly more problems in family functioning prior to becoming homeless than poor families who remain housed.

And what is most clear to us, as clinicians, is that, whatever their source, the family functioning problems that appear to be experienced by poor families need to be addressed in constructive ways in order to increase their effectiveness as family units and, hopefully to prevent eventual homelessness.

The data from this study does not address the particular type of intervention that is appropriate. However, it does suggest some avenues that may be pursued. The data indicates that there are particular domains in which some poor families do not function as effectively as others - problem solving, communication, affective responsiveness and affective involvement. Approaches to therapeutic intervention in these domains of behavior can be conceptualized from at least two different perspectives - intrapsychic or social skills training. In an intrapsychically oriented therapeutic

approach, one may reason that a homeless mother doesn't solve problems effectively because of the depressed feelings resulting from lack of adequate early attachment to her own mother. Alternatively, a social skills approach would argue that a mother who has difficulty solving problems may never have had an opportunity to learn problem solving skills.

The latter approach, based on teaching skills rather than providing insight, would seem to be preferable for a number of reasons. First, the efforts of many poor families to survive physically - that is, to secure food, shelter and safety - allows little time and psychic energy for the inner reflection necessary for insight. A social skills approach would empower them to begin to deal with what is, to them, their most obvious problem, that is, their overwhelming external circumstances. Secondly, social skills training could be delivered more efficiently and over a shorter period of time than traditional therapy. Many of these families move frequently and find it difficult to maintain continuity with any kind of psychological or social service. Thirdly, the feedback is much more immediate and behavior changes are much more obvious in social skills approaches. This immediacy of outcome is crucial in the context of hopelessness. Finally, social skills approaches are not as costly, and therefore more likely to be supported by government insurance.

Consider an example. Joan, a mother of three children under the age of five, was in a homeless shelter for the second time in two years. The staff was concerned that she did not adequately care for her children in terms of their physical or emotional needs. They were quick to point out however that, in their judgement, she did not

abuse or neglect her children, that, as they put it, "she was really trying." When I interviewed this mother, she reported that her job was "to get food and do the wash" for the family (a job she had not been doing very well in her previous apartment according to social work reports), and that the children's father,who lived with her on and off, "hugged the kids, read books to the kids and played with them - he knows how to do that stuff. I don't." She then described her own childhood with two alcoholic parents. "My mother was just always out of it completely. My sister, who was one year older than me, did all the cooking and washing and everything; she was our mother." Finally, she asserted, that the "best thing about the shelter is that the other mothers show me how to do things for my kids."

This mother is clearly asking to be taught how to do mothering. Even if available, insight oriented therapy which would explore her troubled attachment to her mother, would not seem to meet this woman's needs. Skill training directed towards more effective family functioning in domains such as problem solving, communication, affective responsiveness and affective involvement would seem to be one workable approach.

It is interventions of this or other similar types that psychologists must develop and deliver.

And it is toward discovering new and effective strategies to help poor families that a substantial share of our research must be directed.

Finally, it is for resources to provide these types of interventions that psychologists must vigorously advocate at the level of public policy. In today's political climate there is little hope

that the "thousand points of light" will ever shine into the shelters of the poor.

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Table 1

Mean Scores of Homeless and Poor Housed Families on the Family Assessment Device

	Homeless		Housed			
Subscale	M	SD	M	SD	F (1,40)	SIG
PROBLEM SOLVING	2.81	.72	2.06	.29	21.77	.000
COMMUNICATION	2.65	.56	2.22	.29	10.80	.002
ROLES	2.71	.71	2.53	.35	1.13	.295
AFFECTIVE RESPONSIVENESS	2.94	.58	2.13	.38	29.53	.000
AFFECTIVE INVOLVEMENT	2.66	.57	2.34	.43	4.26	.046
BEHAVIOR CONTROL	2.30	.58	2.05	.34	3.09	.086
GENERAL FUNCTIONING	2.63	.70	2.04	.34	12.97	.001